

STATE OF ILLINOIS

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Facility Name & ID Number Rosewood Care Center of Moline# 0036152 Report Period Beginning: 7/1/2002 Ending: 6/30/2003

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days,
(must agree with license). Date of change in licensed beds _____

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>120</u>	Skilled (SNF)	<u>120</u>	<u>43,800</u>	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>120</u>	TOTALS	<u>120</u>	<u>43,800</u>	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Public Aid Recipient	Private Pay	Other	Total	
8	SNF			<u>9,681</u>	<u>9,681</u>	8
9	SNF/PED					9
10	ICF	<u>3,828</u>	<u>19,259</u>		<u>23,087</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>3,828</u>	<u>19,259</u>	<u>9,681</u>	<u>32,768</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed
bed days on line 7, column 4.) 74.81%

D. How many bed-hold days during this year were paid by Public Aid?

70 (Do not include bed-hold days in Section B.)E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)NoneF. Does the facility maintain a daily midnight census? YesG. Do pages 3 & 4 include expenses for services or
investments not directly related to patient care?YES ☐ NO ☒

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES ☐ NO ☒

I. On what date did you start providing long term care at this location?

Date started 5/7/1990

J. Was the facility purchased or leased after January 1, 1978?

YES ☒ Date 5/7/1990 NO ☐

K. Was the facility certified for Medicare during the reporting year?

YES ☒ NO ☐ If YES, enter number
of beds certified 58 and days of care provided 9,681Medicare Intermediary Tri-Span

IV. ACCOUNTING BASIS

ACCRUAL ☒ MODIFIED CASH* ☐ CASH* ☐Is your fiscal year identical to your tax year? YES ☒ NO ☐Tax Year: 6/30/2003 Fiscal Year: 6/30/2003

* All facilities other than governmental must report on the accrual basis.

SEE ACCOUNTANTS' COMPILATION REPORT

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Facility Name & ID Number

Rosewood Care Center of Moline

0036152

Report Period Beginning:

7/1/2002

Ending:

6/30/2003

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	168,007	16,866	9,286	194,159		194,159		194,159		1
2	Food Purchase		144,760		144,760		144,760	(5,769)	138,991		2
3	Housekeeping	100,087	22,573		122,660		122,660		122,660		3
4	Laundry	37,723	18,475		56,198		56,198		56,198		4
5	Heat and Other Utilities			114,549	114,549		114,549	193	114,742		5
6	Maintenance	21,951	6,747	58,329	87,027		87,027	17,614	104,641		6
7	Other (specify):* Sanitation			11,381	11,381		11,381		11,381		7
8	TOTAL General Services	327,768	209,421	193,545	730,734		730,734	12,038	742,772		8
	B. Health Care and Programs										
9	Medical Director			22,775	22,775		22,775		22,775		9
10	Nursing and Medical Records	1,751,619	176,762	1,276	1,929,657		1,929,657		1,929,657		10
10a	Therapy	49,531	2,715	631,417	683,663		683,663	(167,071)	516,592		10a
11	Activities	40,809	1,615	2,980	45,404		45,404		45,404		11
12	Social Services	42,975		2,980	45,955		45,955		45,955		12
13	Nurse Aide Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	1,884,934	181,092	661,428	2,727,454		2,727,454	(167,071)	2,560,383		16
	C. General Administration										
17	Administrative			472,026	472,026		472,026	(353,302)	118,724		17
18	Directors Fees										18
19	Professional Services			3,790	3,790		3,790	39,383	43,173		19
20	Dues, Fees, Subscriptions & Promotions			22,303	22,303		22,303	(6,339)	15,964		20
21	Clerical & General Office Expenses	128,989	38,793	15,527	183,309		183,309	168,929	352,238		21
22	Employee Benefits & Payroll Taxes			271,480	271,480		271,480	27,265	298,745		22
23	Inservice Training & Education										23
24	Travel and Seminar			1,312	1,312		1,312	(33)	1,279		24
25	Other Admin. Staff Transportation			8,289	8,289		8,289	13,473	21,762		25
26	Insurance-Prop.Liab.Malpractice			47,410	47,410		47,410	9,362	56,772		26
27	Other (specify):*										27
28	TOTAL General Administration	128,989	38,793	842,137	1,009,919		1,009,919	(101,262)	908,657		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,341,691	429,306	1,697,110	4,468,107		4,468,107	(256,295)	4,211,812		29

* Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

SEE ACCOUNTANTS' COMPILATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

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Facility Name & ID Number

Rosewood Care Center of Moline

#0036152

Report Period Beginning:

7/1/2002

Ending:

6/30/2003

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			16,587	16,587		16,587	122,847	139,434			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			66,369	66,369		66,369	764,412	830,781			32
33	Real Estate Taxes			97,475	97,475		97,475		97,475			33
34	Rent-Facility & Grounds			1,412,788	1,412,788		1,412,788	(1,401,833)	10,955			34
35	Rent-Equipment & Vehicles			2,474	2,474		2,474		2,474			35
36	Other (specify):*											36
37	TOTAL Ownership			1,595,693	1,595,693		1,595,693	(514,574)	1,081,119			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		188,537	16,014	204,551		204,551	(2,134)	202,417			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			65,700	65,700		65,700		65,700			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		188,537	81,714	270,251		270,251	(2,134)	268,117			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,341,691	617,843	3,374,517	6,334,051		6,334,051	(773,003)	5,561,048			45

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

SEE ACCOUNTANTS' COMPILATION REPORT

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Facility Name & ID Number Rosewood Care Center of Moline

0036152

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VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(5,376)	2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(9,603)	32		10
11	Discounts, Allowances, Rebates & Refunds	(2,134)	39		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(393)	2		13
14	Non-Care Related Interest	(66,369)	32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees	(3,000)	20		17
18	Fines and Penalties				18
19	Entertainment	(33)	24		19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(190)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(3,904)	20		28
29	Other-Attach Schedule Marketing Salary	(57,373)	21		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (148,375)		\$	30

OHF USE ONLY						
48		49	50	51	52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
	Amortization of Organization &			
33	Pre-Operating Expense			33
	Adjustments for Related Organization			
34	Costs (Schedule VII)	(624,628)	Var	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (624,628)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (773,003)		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	\$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule		X			45
46	Other-Attach Schedule		X			46
47	TOTAL (C): (sum of lines 38-46)			\$		47

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Rosewood Care Center of Moline

ID# 0036152

Report Period Beginning: 7/1/2002

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Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	
1		\$ (57,373)	21	1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(57,373)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Rosewood Care Center of Moline

0036152

Report Period Beginning:

7/1/2002

Ending:

6/30/2003

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(5,769)	0	0	0	0	0	0	0	0	0	0	(5,769)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	193	0	0	0	0	0	0	0	0	193	5
6	Maintenance	0	0	17,614	0	0	0	0	0	0	0	0	17,614	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(5,769)	0	17,807	0	0	0	0	0	0	0	0	12,038	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	(167,071)	0	0	0	0	0	0	0	0	0	(167,071)	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	0	(167,071)	0	0	0	0	0	0	0	0	0	(167,071)	16
	C. General Administration													
17	Administrative	0	(472,026)	118,724	0	0	0	0	0	0	0	0	(353,302)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	39,383	0	0	0	0	0	0	0	0	39,383	19
20	Fees, Subscriptions & Promotions	(7,094)	0	755	0	0	0	0	0	0	0	0	(6,339)	20
21	Clerical & General Office Expenses	(57,373)	0	226,302	0	0	0	0	0	0	0	0	168,929	21
22	Employee Benefits & Payroll Taxes	0	0	27,265	0	0	0	0	0	0	0	0	27,265	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	(33)	0	0	0	0	0	0	0	0	0	0	(33)	24
25	Other Admin. Staff Transportation	0	0	13,473	0	0	0	0	0	0	0	0	13,473	25
26	Insurance-Prop.Liab.Malpractice	0	0	9,362	0	0	0	0	0	0	0	0	9,362	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(64,500)	(472,026)	435,264	0	0	0	0	0	0	0	0	(101,262)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(70,269)	(639,097)	453,071	0	0	0	0	0	0	0	0	(256,295)	29

Facility Name & ID Number Rosewood Care Center of Moline# 0036152

Report Period Beginning:

7/1/2002

Ending:

6/30/2003

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Larry Vander Maten	75.00%	See Attached List		See Attached List		
Darrell Hoefling	25.00%	See Attached List		See Attached List		

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	17 Management Fee	\$ 472,026	HSM Management	100.00%	\$	\$ (472,026)	1
2	V							2
3	V	10a Therapy	631,417	Rosewood Therapy Company, Inc.	0.00%	464,346	(167,071)	3
4	V							4
5	V	34 Rent	1,412,788	Moline Real Estate, Inc.	0.00%		(1,412,788)	5
6	V	30 Depreciation		Moline Real Estate, Inc.		100,560	100,560	6
7	V	32 Interest		Moline Real Estate, Inc.		829,056	829,056	7
8	V	32 Amortization - Loan Fee		Moline Real Estate, Inc.		11,328	11,328	8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 2,516,231			\$ 1,405,290	\$ * (1,110,941)	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rosewood Care Center of Moline# 0036152Report Period Beginning: 7/1/2002Ending: 6/30/2003

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	17 See Schedule VIII	\$	HSM Management Services, Inc.	100.00%	\$ 118,724	\$ 118,724
16	V	21 See Schedule VIII		HSM Management Services, Inc.	100.00%	226,302	226,302
17	V	22 See Schedule VIII		HSM Management Services, Inc.	100.00%	27,265	27,265
18	V	25 See Schedule VIII		HSM Management Services, Inc.	100.00%	13,473	13,473
19	V	30 See Schedule VIII		HSM Management Services, Inc.	100.00%	22,287	22,287
20	V	34 See Schedule VIII		HSM Management Services, Inc.	100.00%	10,955	10,955
21	V	19 See Schedule VIII		HSM Management Services, Inc.	100.00%	39,383	39,383
22	V	26 See Schedule VIII		HSM Management Services, Inc.	100.00%	9,362	9,362
23	V	6 See Schedule VIII		HSM Management Services, Inc.	100.00%	17,614	17,614
24	V	5 See Schedule VIII		HSM Management Services, Inc.	100.00%	193	193
25	V	20 See Schedule VIII		HSM Management Services, Inc.	100.00%	755	755
26	V						
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$			\$ 486,313	\$ * 486,313

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

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Facility Name & ID Number Rosewood Care Center of Moline # 0036152 Report Period Beginning: 7/1/2002 Ending: 6/30/2003

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Larry Vander Maten	President	Management	75.00%	609,743	2	6.17%	Salary	\$ 40,071	17-8	1
2	Darrell Hoefling	Vice-President	Management	25.00%	333,632	2	6.17%	Salary	21,925	17-8	2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 61,996		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees).
FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME.
ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rosewood Care Center of Moline# 0036152

Report Period Beginning:

7/1/2002Ending: 7/30/2003

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

Name of Related Organization HSM Management Services, Inc.Street Address 11701 Borman Drive, Suite 315City / State / Zip Code St. Louis, MO 63146Phone Number (314) 994-9070Fax Number (314) 994-9912

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	17 Salaries - Officers	Total Cost	78,214,895	17	\$ 1,005,371	\$ 1,005,371	4,823,095	\$ 61,996	1
2	21 Salaries - Others	Total Cost	78,214,895	17	3,183,939	3,183,939	4,823,095	196,337	2
3	22 Payroll Taxes	Total Cost	78,214,895	17	296,707		4,823,095	18,296	3
4	22 Employee Benefits	Total Cost	78,214,895	17	59,110		4,823,095	3,645	4
5	25 Travel	Total Cost	78,214,895	17	207,136		4,823,095	12,773	5
6	30 Depreciation	Total Cost	78,214,895	17	351,450		4,823,095	21,672	6
7	34 Building Rent	Total Cost	78,214,895	17	177,648		4,823,095	10,955	7
8	19 Professional Services	Total Cost	78,214,895	17	638,666		4,823,095	39,383	8
9	21 Telephone	Total Cost	78,214,895	17	223,118		4,823,095	13,758	9
10	26 Insurance	Total Cost	78,214,895	17	151,827		4,823,095	9,362	10
11	21 Taxes, Licenses, & Ofc Sup	Total Cost	78,214,895	17	262,831		4,823,095	16,207	11
12	6 Maintenance	Total Cost	78,214,895	17	283,265		4,823,095	17,467	12
13	5 Heat & Other Utilities	Total Cost	78,214,895	17	3,126		4,823,095	193	13
14	20 Dues & Subscriptions	Total Cost	78,214,895	17	12,246		4,823,095	755	14
15	17 Direct - Admin	Direct Cost	1	1	56,728	56,728	1	56,728	15
16	17 Direct - Admin	Direct Cost	15	16	879,273	879,273	0	0	16
17	22 Direct - Payroll Taxes	Direct Cost	1	1	5,324		1	5,324	17
18	22 Direct - Payroll Taxes	Direct Cost	15	16	75,932		0	0	18
19	30 Direct - Depreciation	Direct Cost	1	1	615		1	615	19
20	30 Direct - Depreciation	Direct Cost	13	16	11,538		0	0	20
21	25 Direct - Travel	Direct Cost	1	1	700		1	700	21
22	25 Direct - Travel	Direct Cost	11	16	17,061		0	0	22
23	6 Direct - Maintenance	Direct Cost	1	1	147		1	147	23
24	6 Direct - Maintenance	Direct Cost	13	16	6,044		0	0	24
25	TOTALS				\$ 7,909,802	\$ 5,125,311		\$ 486,313	25

SEE ACCOUNTANTS' COMPILATION REPORT

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

1		2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related Long-Term												
1	Bank of America		X	Mortgage Refinancing	\$85,767.00	10/26/99	\$ 10,312,500	\$ 9,893,204	11/2009	8.89%	\$ 899,758	1	
2	Amortization of Loan Fees										11,328	2	
3	Less: Related Party Interest										(70,702)	3	
4	Interest Income										(9,603)	4	
5												5	
	Working Capital												
6												6	
7												7	
8												8	
9	TOTAL Facility Related				\$85,767.00		\$ 10,312,500	\$ 9,893,204			\$ 830,781	9	
	B. Non-Facility Related*												
10												10	
11												11	
12												12	
13												13	
14	TOTAL Non-Facility Related						\$	\$			\$	14	
15	TOTALS (line 9+line14)						\$ 10,312,500	\$ 9,893,204			\$ 830,781	15	

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 0 Line # N/A

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.
(See instructions.) SEE ACCOUNTANTS' COMPILATION REPORT

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.
(See instructions.)

Facility Name & ID Number **Rosewood Care Center of Moline**# **0036152** Report Period Beginning: **7/1/2002** Ending: **6/30/2003****IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)****B. Real Estate Taxes**

		Important , please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.		
1. Real Estate Tax accrual used on 2002 report.			\$	117,715 1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)			\$	94,092 2
3. Under or (over) accrual (line 2 minus line 1).			\$	(23,623) 3
4. Real Estate Tax accrual used for 2003 report. (Detail and explain your calculation of this accrual on the lines below.)			\$	121,098 4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)			\$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)			\$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.			\$	97,475 7
Real Estate Tax History:				
Real Estate Tax Bill for Calendar Year:	1998	84,641	8	
	1999	89,050	9	
	2000	91,822	10	
	2001	93,421	11	
	2002	96,110	12	
2001 Payment - \$70,065				
2002 Payment - \$24,027				
Accrual = Balance of 2002 tax bill (72,082) + 1/2 estimated 2003 tax bill (49,016)				
				FOR OHF USE ONLY
	13	FROM R. E. TAX STATEMENT FOR 2002	\$	13
	14	PLUS APPEAL COST FROM LINE 5	\$	14
	15	LESS REFUND FROM LINE 6	\$	15
	16	AMOUNT TO USE FOR RATE CALCULATION	\$	16

NOTES:

1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

SEE ACCOUNTANTS' COMPILATION REPORT

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2002 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2002 real estate tax costs, as well as copies of your real estate tax bills for calendar 2002.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2002 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2003 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2002 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Rosewood Care Center of Moline COUNTY Rock Island

FACILITY IDPH LICENSE NUMBER 0036152

CONTACT PERSON REGARDING THIS REPORT Chuck Schmitz

TELEPHONE (314) 994-9070 FAX #: (314) 994-9912

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2002 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2002.

	(A)	(B)	(C)	(D) <u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
	<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	
1.	<u>07-649-95-00</u>	<u>7300 34 AVE</u>	\$ <u>96,109.56</u>	\$ <u>96,109.56</u>
2.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
3.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
4.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
5.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
6.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
7.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
8.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
9.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
10.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
		TOTALS	\$ <u><u>96,109.56</u></u>	\$ <u><u>96,109.56</u></u>

B. Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. Tax Bills

Attach a copy of the 2002 tax bills which were listed in Section A to this statement. Be sure to use the 2002 tax bill which is normally paid during 2003.

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet:
 39,200

B. General Construction Type:
 Exterior
 Brick
 Frame
 Wood
 Number of Stories
 1

C. Does the Operating Entity?
 ☐ (a) Own the Facility
 ☒ (b) Rent from a Related Organization.
 ☐ (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity?
 ☐ (a) Own the Equipment
 ☒ (b) Rent equipment from a Related Organization.
 ☐ (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized?
 ☐ YES
 ☒ NO

If so, please complete the following:

1. Total Amount Incurred:
 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization:
 4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Nursing Home	4.4 Acres	1989	\$ 210,330	1
2					2
3	TOTALS			\$ 210,330	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rosewood Care Center of Moline

0036152

Report Period Beginning:

7/1/2002

Ending:

6/30/2003

XL OWNERSHIP COSTS (continued)**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1 Beds*	2 FOR OHF USE ONLY	3 Year Acquired	4 Year Constructed	5 Cost	6 Current Book Depreciation	7 Life in Years	8 Straight Line Depreciation	9 Adjustments	10 Accumulated Depreciation	11
4	120			1990	\$ 2,845,310	\$	40	\$ 71,133	\$ 71,133	\$ 936,584	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Site Improvements		1990		277,100		20-25	11,096	11,096	146,108	9
10	Curbing		1991		2,743		25	110	110	1,320	10
11	Landscaping		1991		4,560		25	182	182	2,169	11
12	Irrigation System		1993		10,257		25	410	4,066	4,069	12
13	Water Meter & Back		1993		1,803		25	72	72	708	13
14	Walk-in Cooler		1990		7,845		20	392	392	5,161	14
15	Sinks		1990		6,386		10*-20	62	62	5,967	15
16	Exhaust Hood w/Fire Extinguisher		1990		6,317		10			6,317	16
17	Generator		1990		15,779		20	789	789	10,388	17
18	Signage		1990		2,721		15	181	181	2,395	18
19	Facility Signs		1990		1,757		10			1,757	19
20	Cubicle Curtain Track		1990		6,176		10			6,176	20
21	Fire Alarm System		1990		99,726		10			99,726	21
22	Hot Water Heater		1990		6,706		10			6,706	22
23	Water Heater Tank		1990		7,961		10			7,961	23
24	Wallcovering		1990		24,650		10			24,650	24
25	Carpeting		1990		8,025		10			8,025	25
26	Steel Trash Doors		1991		1,825		10			1,825	26
27	Parking Lot Addition		2000		11,485		25	460	460	1,224	27
28											28
29	Leasehold Improvements - Facility:										29
30	Painting/Floor Stripping		1995		9,426		7			9,426	30
31	Carpeting		1995		292		7	12		292	31
32	Carpeting		1996		14,000	1,167	7	1,167		14,000	32
33	Cabinet Work		1996		1,868	155	7	155		1,868	33
34	Base Stripping		1996		1,509	148	7	148		1,509	34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

SEE ACCOUNTANTS' COMPILATION REPORT

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	2 Year Constructed	3 Cost	4 Current Book Depreciation	5 Life in Years	6 Straight Line Depreciation	7 Adjustments	8 Accumulated Depreciation	9
37	Painting	1996	\$ 19,996	\$ 2,854	7	\$ 2,854	\$	\$ 19,325	37
38	Wallcovering/Bathroom Mirrors/Plants	1999	11,651	1,664	7	1,664		7,189	38
39	Drapery/Office Space/Counter	1999	2,256	321	7	321		1,510	39
40	Wallcovering/Bathroom Mirrors/Plants	1999	15,783	2,254	7	2,254		8,593	40
41	Carpeting	2000	4,718	674	7	674		2,129	41
42	Flooring	2000	2,371	338	7	338		875	42
43	Countertops	2000	3,894	557	7	557		1,437	43
44	Paneling	2000	1,270	182	7	182		469	44
45	Room Signs	2000	1,082	154	7	154		399	45
46	Sink	2000	1,935	277	7	277		714	46
47	Computer Cabling	2000	2,895	413	7	413		1,034	47
48	Flooring	2000	5,028	718	7	718		1,676	48
49	Wallpaper	2001	15,605	2,229	7	2,229		4,644	49
50	Wallcovering	2002	648	93	7	93		116	50
51	Repave Parking Lot	2002	11,830	1,690	7	1,690		2,253	51
52									52
53	Leasehold Improvements - Managment Company:								53
54	Office Construction/ Improvements	1995	472		5			472	54
55	Office Design	1995	43		5			43	55
56	Office Shelving	1996	101		4			101	56
57	Office Expansion	1996	446		4			446	57
58	Office Expansion	1997	1,193		3			1,193	58
59	Office Expansion	1998	673		3			673	59
60	Office Addition	1999	332		3			332	60
61	Door Locks	1999	166		3	23	23	166	61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 3,480,615	\$ 15,900		\$ 100,810	\$ 88,566	\$ 1,362,120	70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 283,783	\$ 687	\$ 30,059	\$ 29,372	5-10 Yrs	\$ 185,703	71
72	Current Year Purchases	6,698		670	670	5-10 Yrs	670	72
73	Fully Depreciated Assets	414,192					414,192	73
74								74
75	TOTALS	\$ 704,673	\$ 687	\$ 30,729	\$ 30,042		\$ 600,565	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	HSM Management	Various	Various	\$ 28,248	\$	\$ 7,895	\$ 7,895	4 Yrs	\$ 13,912	76
77										77
78										78
79										79
80	TOTALS			\$ 28,248	\$	\$ 7,895	\$ 7,895		\$ 13,912	80

E. Summary of Care-Related Assets

	1 Reference	2 Amount	
81	Total Historical Cost (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 4,423,866	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 16,587	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 139,434	83 **
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 122,847	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 1,976,597	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	Section Not Applicable	\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92	Section Not Applicable	\$	92
93			93
94			94
95		\$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

SEE ACCOUNTANTS' COMPILATION REPORT

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: Schedule Not Applicable

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?

If NO, see instructions.

☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			7

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized by the length of the lease _____.

9. Option to Buy: ☐ YES ☐ NO Terms: _____ *

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental?

☐ YES ☐ NO

16. Rental Amount for movable equipment: \$ _____ Description: _____

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	21

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

11. Rent to be paid in future years under the current rental agreement:

Fiscal Year Ending Annual Rent

12. /2004 \$ _____

13. /2005 \$ _____

14. /2006 \$ _____

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

SEE ACCOUNTANTS' COMPILATION REPORT

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO N/A - ONLY HIRE CERTIFIED AIDES If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.	2. CLASSROOM PORTION: IN-HOUSE PROGRAM <input type="checkbox"/> IN OTHER FACILITY <input type="checkbox"/> COMMUNITY COLLEGE <input type="checkbox"/> HOURS PER AIDE _____	3. CLINICAL PORTION: IN-HOUSE PROGRAM <input type="checkbox"/> IN OTHER FACILITY <input type="checkbox"/> HOURS PER AIDE _____
---	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

		1		2		3	4
		Facility					
		Drop-outs	Completed	Contract	Total		
1	Community College Tuition	\$	\$	\$	\$		
2	Books and Supplies						
3	Classroom Wages (a)						
4	Clinical Wages (b)						
5	In-House Trainer Wages (c)						
6	Transportation						
7	Contractual Payments						
8	Nurse Aide Competency Tests						
9	TOTALS	\$	\$	\$	\$		
10	SUM OF line 9, col. 1 and 2 (e)	\$					

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

\$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
 (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
 (c) For in-house training programs only. Do not include fringe benefits.
 (d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.

- (e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
 (f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.
SEE ACCOUNTANTS' COMPILATION REPORT

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
					Units	Cost				
1	Licensed Occupational Therapist	10a-8	hrs	\$	27,153	\$ 262,650	\$	27,153	\$ 262,650	1
2	Licensed Speech and Language Development Therapist	10a-8	hrs		990	14,598		990	14,598	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a-8	hrs		27,983	187,097	2,715	27,983	189,812	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-8	# of prescrpts				162,965		162,965	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Ambulance, Laboratory, Enterals, Other (specify): & X-Ray	39-8				13,880	25,572		39,452	13
14	TOTAL			\$	56,126	\$ 478,225	\$ 191,252	56,126	\$ 669,477	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 717,495	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 62,000)	913,206		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	2,867		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,633,568	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost	132,866		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost			16
17	Accumulated Depreciation (book methods)	(80,380)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 52,486	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,686,054	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 210,461	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	698,623		29
30	Accrued Salaries Payable	207,643		30
31	Accrued Taxes Payable (excluding real estate taxes)	100,584		31
32	Accrued Real Estate Taxes(Sch.IX-B)	121,098		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Accrued Management Fees	177,600		36
37	Accrued Rent	41,069		37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,557,078	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,557,078	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 128,976	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,686,054	\$	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 107,280	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 107,280	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	208,996	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	(187,300)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 21,696	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 128,976	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

VII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.
Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 6,754,069	1
2	Discounts and Allowances for all Levels	(2,451,489)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 4,302,580	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	2,300,921	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 2,300,921	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	3,600	13
14	Non-Patient Meals	5,376	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 8,976	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	9,603	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 9,603	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Lab Discounts	2,134	28
28a	Miscellaneous	3,925	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 6,059	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 6,628,139	30

	Expenses	Amount	
	A. Operating Expenses		
31	General Services	730,734	31
32	Health Care	2,727,454	32
33	General Administration	1,009,919	33
	B. Capital Expense		
34	Ownership	1,595,693	34
	C. Ancillary Expense		
35	Special Cost Centers	204,551	35
36	Provider Participation Fee	65,700	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 6,334,051	40
41	Income before Income Taxes (line 30 minus line 40)**	294,088	41
42	Income Taxes	(85,092)	42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 208,996	43

* This must agree with page 4, line 45, column 4.

** Does this agree with taxable income (loss) per Federal Income Tax Return? Yes If not, please attach a reconciliation.

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation. SEE ACCOUNTANTS' COMPILATION REPORT

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

Facility Name & ID Number Rosewood Care Center of Moline# 0036152Report Period Beginning: 7/1/2002Ending: 6/30/2003

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	2,076	2,183	\$ 54,900	\$ 25.15	1
2	Assistant Director of Nursing	2,008	2,112	49,892	23.62	2
3	Registered Nurses	17,865	18,791	388,776	20.69	3
4	Licensed Practical Nurses	24,653	25,931	442,075	17.05	4
5	Nurse Aides & Orderlies	69,657	73,268	731,816	9.99	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	3,161	3,325	49,531	14.90	8
9	Activity Director					9
10	Activity Assistants	4,961	5,218	40,809	7.82	10
11	Social Service Workers	5,792	6,092	42,975	7.05	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	19,441	20,448	168,007	8.22	15
16	Dishwashers					16
17	Maintenance Workers	2,036	2,142	21,951	10.25	17
18	Housekeepers	13,933	14,656	100,087	6.83	18
19	Laundry	4,983	5,241	37,723	7.20	19
20	Administrator					20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	12,535	13,185	128,989	9.78	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	6,507	6,844	84,160	12.30	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	189,608	199,436	\$ 2,341,691 *	\$ 11.74	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	390	\$ 9,286	1-3	35
36	Medical Director	Contract	22,775	9-3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	105	2,980	11-3	44
45	Social Service Consultant	105	2,980	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	600	\$ 38,021		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses		\$		50
51	Licensed Practical Nurses	23	611	10-3	51
52	Nurse Aides	37	665	10-3	52
53	TOTAL (lines 50 - 52)	60	\$ 1,276		53

SEE ACCOUNTANTS' COMPILATION REPORT

XIX. SUPPORT SCHEDULES

A. Administrative Salaries			
Name	Function	Ownership %	Amount
Glenn Doyle	Administration	0.00%	\$ 8,161
Toni Hunter	Administration	0.00%	48,567
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 56,728
B. Administrative - Other			
Description			Amount
Management Fees			\$ 472,026
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 472,026
C. Professional Services			
Vendor/Payee	Type		Amount
C.J. Schlosser & Company	Accountant/Consultant		\$ 3,790
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$2500 attach copy of invoices.)			\$ 3,790
D. Employee Benefits and Payroll Taxes			
Description			Amount
Workers' Compensation Insurance			\$ 56,269
Unemployment Compensation Insurance			19,754
FICA Taxes			177,613
Employee Health Insurance			14,342
Employee Meals			
Illinois Municipal Retirement Fund (IMRF)*			
HSM Management Allocation			27,265
Employee Uniforms			1,230
Employee Relations			2,272
TOTAL (agree to Schedule V, line 22, col.8)			\$ 298,745
E. Schedule of Non-Cash Compensation Paid to Owners or Employees			
Description	Line #		Amount
Section Not Applicable			\$
TOTAL			\$
F. Dues, Fees, Subscriptions and Promotions			
Description			Amount
IDPH License Fee			\$
Advertising: Employee Recruitment			6,795
Health Care Worker Background Check (Indicate # of checks performed 92)			1,106
Misc. Dues/Subscriptions			7,308
Promotional Advertising			4,094
Management Company Allocations			755
Less: Public Relations Expense			(157)
Non-allowable advertising			(33)
Yellow page advertising			(3,904)
TOTAL (agree to Sch. V, line 20, col. 8)			\$ 15,964
G. Schedule of Travel and Seminar**			
Description			Amount
Out-of-State Travel			\$
In-State Travel			
Seminar Expense			1,279
Entertainment Expense			(
(agree to Sch. V, line 24, col. 8)			
TOTAL			\$ 1,279

* Attach copy of IMRF notifications
SEE ACCOUNTANTS' COMPILATION REPORT

****See instructions.**

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

1		2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008
1	Schedule Not Applicable		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number **Rosewood Care Center of Moline**

STATE OF ILLINOIS

0036152

Report Period Beginning:

7/1/2002

Ending:

Page 23

6/30/2003

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? Yes
If YES, give association name and amount. Illinois Health Care Association
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? N/A
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 10 yrs
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 54,963 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over. N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. \$ 65,700
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.

SEE ACCOUNTANTS' COMPILATION REPORT

- (13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 0 Has any meal income been offset against related costs? Yes Indicate the amount. \$ 5,376
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
c. What percent of all travel expense relates to transportation of nurses and patients? N/A
d. Have vehicle usage logs been maintained? N/A
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? N/A
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? Yes
Firm Name: C.J. Schlosser & Company The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? No If no, please explain. Copy attached to RCC-East Peoria
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? N/A
Attach invoices and a summary of services for all architect and appraisal fees.

ROSEWOOD CARE CENTER INC. OF MOLINE
IDPH ID #0036152
ATTACHMENT TO SCHEDULE V, LINE 25
6/30/2003

OTHER ADMIN. STAFF TRANSPORTATION:

MILEAGE REIMBURSEMENT**	<u>\$ 8,289</u>
	<u><u>\$ 8,289</u></u>

**ALL MILEAGE REIMBURSEMENTS ARE FOR TRAVEL VOUCHERS
SUBMITTED WHICH WERE LESS THAN \$250.00 EACH

ROSEWOOD CARE CENTER INC. OF MOLINE
IDPH ID #0036152
ATTACHMENT TO SCHEDULE VII, SECTION A.
6/30/2003

RELATED NURSING HOME:

ROSEWOOD CARE CENTER OF ALTON
ROSEWOOD CARE CENTER OF EAST PEORIA
ROSEWOOD CARE CENTER OF EDWARDSVILLE
ROSEWOOD CARE CENTER OF ELGIN
ROSEWOOD CARE CENTER OF GALESBURG
ROSEWOOD CARE CENTER OF INVERNESS
ROSEWOOD CARE CENTER OF JOLIET
ROSEWOOD CARE CENTER OF NORTHBROOK
ROSEWOOD CARE CENTER OF PEORIA
ROSEWOOD CARE CENTER OF ROCKFORD
ROSEWOOD CARE CENTER OF ST. CHARLES
ROSEWOOD CARE CENTER OF ST. LOUIS
ROSEWOOD CARE CENTER OF SWANSEA

CITY:

ALTON, IL
EAST PEORIA, IL
EDWARDSVILLE, IL
ELGIN, IL
GALESBURG, IL
INVERNESS, IL
JOLIET, IL
NORTHBROOK, IL
PEORIA, IL
ROCKFORD, IL
ST. CHARLES, IL
ST. LOUIS, MO
SWANSEA, IL

OTHER RELATED BUSINESS ENTITIES:

HSM MANAGEMENT SERVICES, INC.
MOLINE REAL ESTATE, INC.
HSM DEVELOPMENT, INC.
RCC HOLDING COMPANY
ROSEWOOD HOME HEALTH
ROSEWOOD THERAPY SERVICES

TYPE OF BUSINESS:

MANAGEMENT CO.
REAL ESTATE LSG.
DEVELOPMENT CO.
HOLDING COMPANY
HOME HEALTH CO.
THERAPY COMPANY